

# **Evidence Favors Snoezelen Rooms for Recreation and Relaxation, Not for Treating Aggressive Behavior**



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There has been increased interest recently in the use of Snoezelen rooms for individuals with developmental disabilities. Snoezelen rooms are "multi-sensory" environments, and typically have soft floors, cushions, background classical music or nature sounds, blinking lights, bubble tubes, massaging chairs, and scents. There are thousands of Snoezelen installations in over 30 countries, with 700 in North America. Here at MHCP, there is a fully equipped Snoezelen room on the Bayview Dual Diagnosis Unit (BDDP) and a Snoezelen Cart on the Geriatric Services Program.

Although Snoezelen rooms were originally intended to provide recreation and sensory stimulation for people living in institutions, claims have been made that they can be used to reduce self-injury and aggression. Snoezelen rooms have proliferated as a treatment for many serious problems with adults and children with intellectual disabilities. But so far, there is no good scientific evidence supporting this use. Behavioral methods have proven effective for treating aggression and self-injury among clients with severe intellectual disabilities; however, few institutions have specially trained staff to run behavioral treatments. A Snoezelen room is relatively attractive to institutional use, because it is easy to implement (although expensive to install).

Recently, the Research Department worked with Larry Silk and Nancy Pilon on the BDDP to study whether the Snoezelen room could be used to reduce aggressive and destructive behavior in three adult clients with developmental disability. We wanted to see whether any positive effects of Snoezelen would generalize to behavior outside of the room, if access to the room was permitted only when the clients showed calm and socially appropriate behavior.

The participants were three adult male inpatients from BDDP, who were among the most aggressive and destructive on the ward. Staff identified four or five target disruptive behaviors chosen for each client, such as hitting staff and co-patients, spitting, threatening, and being destructive to property. Staff also suggested two prosocial

behaviors for each participant (e.g., saying "please" and "thank you" when making a request, speaking slowly enough to be understood etc.,).

First, we counted how often each client displayed the target disrupted behaviors during a 28-day period. Each client was then given access to the Snoezelen room for 30-45 minutes each weekday for the next 28 days. No access to the room was permitted for the following 28 days, and finally the participant was again given access to the room for a final 28-day period. During each of these periods, staff recorded the number of target aggressive and prosocial behaviors shown by each client.

The results showed that the Snoezelen room did not decrease clients' aggressive or destructive behaviors. Instead, disruptive behavior increased during the weeks that clients had access to the Snoezelen room. There also seemed to be a small increase in prosocial behaviors over the total 16 weeks of the study.

We recommend that institutions continue to use existing Snoezelen rooms for their original purpose - that is, relaxation and recreation. Clients with developmental delay rarely have the opportunity to engage in relaxing activities in a quiet, stimulating environment, and so the value of Snoezelen for this purpose is considerable. For treating aggressive behavior or increasing prosocial behaviour, however, the balance of evidence supports behavioral methods. Many successful programs for aggression have been reported in books and journal articles. Most of these programs involve reliable measurement of specific behaviors and whole-ward behavioral interventions, including such components as token economies, extinction (systematic withdrawal of reinforcement for disruptive behavior), DRO (differential reinforcement of other behavior), and cognitive behavior modification. Appropriate behavioral training, equivalent to the level of behavioral technicians, should be provided to staff members who run such programs.

These intensive programs, while also costly, have the best chance of leading to lasting improvement in client behavior.

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